Connecticut State Medical Society
FOUNDED IN 1792
160 St. Ronan Street, New Haven, CT 06511-2390 (203) 865-0587 FAX (203) 865-4997

Connecticut State Medical Society
Senate Bill 16 An Act Concerning Standards in Health Care Provider Contracts
Insurance and Real Estate Committee
January 25, 2011

Senator Crisco, Representative Megna and Members of the Insurance and Real Estate Committee, on behalf of the more than 7,000 physicians and physicians in training of the Connecticut State Medical Society (CSMS) thank you for the opportunity to present this testimony to you today in support of SB 16 **An Act Concerning Standards in Health Care Provider Contracts**. We sincerely thank Chairmen Crisco and Megna and members of the Committee for their continuing efforts to develop a consensus on issues aimed at strengthening the health care contracting process between physicians and insurers and other payors of health care in this state.

The language before you today represents a working draft and a continuation of efforts to appropriately address contracting and specific payment issues raised by physicians throughout the state. We fully believe that final language will be in the best interest of physicians and the patients for whom they provide medically necessary care.

Section 1 of this bill attempts to update the state's timely payment statutes to acknowledge the movement in health care to the electronic submission and payment of medical claims. This allows for a more efficient and effective process and brings Connecticut law up to date with today's standards of timeliness of payment. Language in this section should ultimately establish timeframes that recognize and reflect this shift from paper claims to electronically submitted claim information and also incentivize further implementation of electronic claims processing and systems by both the payors of claims and those submitting medical claims for payment.

A concern exists among physicians regarding contracting procedures that allow insurers to require participation in any future product developed by the insurer without current knowledge of what those products or plan types may be or what requirements or responsibilities may fall squarely on physicians. This creates a problem of practice management, care management and professional liability. **Section 2** of this bill attempts to provide an opportunity for a physician to determine whether or not a product is appropriate for their respective practice and patient population and allow for individual determination on participation at the plan and product level as those plans and products are developed and presented by insurers and other entities. We understand concerns raised by insurers regarding the cost to potentially re-credential or re-contract with the establishment of new products. However, we believe certain methods exist, such as allowing existing credentialed providers to "opt-in" to future products, and will continue discussions to develop appropriate methods that will make the "opt-in" approach to be as efficient and effective as possible without creating undue burden on the patient, physician or insurer.

All citizens who purchase health insurance deserves to know that an adequate network will exist when seeking medical care, regardless of the type of care being sought. Patients should know in advance of seeking or receiving care that insurer and other entity networks are adequate for primary care, medical and surgical specialty care, and mental and behavioral health care service access. The Commissioner of the Connecticut Insurance Department (CID) should be granted the authority to ensure that such vibrant networks exist in the State of Connecticut for patients who have health insurance and who seek medically necessary care. Although insurers must meet the standards of certain national entities for accreditation, it is critical that we ensure such standards are appropriate for Connecticut and that all insurers and other networks maintain consistent standards so that patients have assurances of network service access. **Section 3** attempts to accomplish this goal of providing a clear standard that entities must adhere to in Connecticut. CSMS also believes that these network adequacy standards should take into consideration and fully recognize the diverse populations that are cared for in Connecticut. These standards should make sure that disadvantaged populations have physicians of the similar ethnic, racial and cultural backgrounds available within the network, as well as physicians who have a specific understanding of the unique needs of these diverse populations. The study that CSMS initiated over the past two years on health care disparities and health equities has demonstrated the importance of physicians having an understanding of the cultural and related barriers to the access of medical care in the State of Connecticut. In order for a network to truly be adequate, it must be diverse. We believe an adequate network is a diverse network.

Sections 4 of this bill attempts to address another ongoing concern that is increasingly harming patients and the physicians who provide their medical care in Connecticut. Prior- Authorization is a process in which physicians obtain authorization to perform a medical service or procedure, such as a surgery, prior to delivering the medically necessary care. However, in some instances and for various reasons, services previously authorized are later denied by insurers. It is very burdensome and quite problematic when a physician and/or a physician's office staff personnel spend considerable time in advance of medical care providing justification of the necessity of the procedure or service, only to after providing the medically necessary care receive information that the physician will not receive payment. If a service or procedure has been authorized by an insurer or other entity and then provided by a physician, full payment should be made. Otherwise, all that is happening is an insurer is providing false coverage to the patient and false hope to the physician that payment will be provided. Coverage of a service or procedure in this case should constitute payment for the service or procedure provided so long as prior authorization has been received. This section will go a long way to ensuring that any procedure or service that is appropriately authorized in advance of the medical care being provided is appropriately and sufficiently paid for by the authorizing party or its agent.

Thank you for the opportunity to present this testimony for you today. We look forward to continuing our work on SB 16.